NIGERIAQUAL
PMTCT AUDIT FORM

A. FACILITY DETAILS

FACILITY NAME: _____

STATE: _____ LGA: _____

IMPLEMENTING PARTNER: _____

NAME OF ASSESSOR: _____

Date of Assessment (dd/mm/yyyy): ___/___/_____

Review Period ___/___/_____ To ___/___/_____

B. LEVEL (Check one)

☐ Primary Health Centre ☐ Secondary Hospital

Tertiary Hospital
☐ Federal med. Centre ☐ Specialist Hospital
☐ Teaching Hospital

Ownership ☐ Public ☐ Faith-based ☐ Private

C. PATIENT TYPE

☐ Booked
- ☐ HIV-infected prior to booking
- ☐ Unknown status prior to booking

☐ Unbooked
- ☐ Known HIV-infected prior to arriving in labor
- ☐ Unknown status prior to arriving in labor

If unbooked, fill Section D and then skip to Section G

D. PATIENT DEMOGRAPHICS

Patient ID ___-___-_____ Hospital No. _____ Patient ANC No. _____

Last Name _____ RNL Serial No. _____ Age ___ Parity ___.___

First Name _____ LMP (dd/mm/yyyy) ___/___/_____

EDD (dd/mm/yyyy) ___/___/_____ Date of 1st booking (dd/mm/yyyy) ___/___/_____ Gestational age at 1st booking ___ weeks

E. ANC TESTING AND COUNSELING *(Complete this section for only booked patients)*

Woman counseled for HCT ☐ Yes ☐ No

Woman accepted HCT ☐ Yes ☐ No *(If YES, complete section E, if NO, go to section G)*

HCT done ☐ Yes ☐ No Date HCT done (dd/mm/yyyy) ___/___/_____

Time HCT done ☐ Before pregnancy (Past) ☐ ANC ☐ Labor/Delivery ☐ After delivery

HIV status ☐ Positive ☐ Negative Date of HIV diagnosis (dd/mm/yyyy) ___/___/_____

Infant feeding counseling received ☐ Yes ☐ No

Woman agreed to partner notification ☐ Yes ☐ No

CD4 ordered ☐ Yes ☐ No Date ordered ___/___/_____ Date done (dd/mm/yyyy): ___/___/_____

Date result received (dd/mm/yyyy): ___/___/_____ CD4 count _____

WHO Clinical Stage ___ ☐ Not Recorded

Patient found to be eligible for ART by Clinician ☐ Yes ☐ No ☐ Not Recorded

ARV received ☐ Yes ☐ No If yes, date regimen started (dd/mm/yyyy): ___/___/_____

Pre pregnancy HAART ☐ Yes ☐ No

Ante partum ARV: ☐ ZDV (only opt A) ☐ HAART for prophylaxis (opt B) ☐ HAART for treatment ☐ None ☐ Unknown/Not Indicated ☐ Other

Referred for ART: ☐ Yes ☐ No ☐ Not applicable ☐ Not Recorded

F. PARTNER REGISTER

Partner of HIV + woman tested and received result ☐ Yes ☐ No ☐ Not Recorded

Partner HIV status: ☐ Positive ☐ Negative ☐ Not Recorded

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G. DELIVERY REGISTER *(Fill this section for all booked and unbooked patients)*

Date of delivery (dd/mm/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Maternal intrapartum ARV regimen received: ☐ Yes ☐ No

Maternal intrapartum ARV regimen received

☐ sdNVP+3TC+ZDV (opt A) ☐ HAART for prophylaxis (opt B) ☐ HAART for treatment ☐ None ☐ Unknown/Not Indicated ☐ Other

Mode of delivery: ☐ Vaginal ☐ Elective C section ☐ Emergency C section ☐ Other (specify): _____

Gestational age at delivery ☐☐ weeks

Episiotomy: ☐ Yes ☐ No

Infant feeding choice: ☐ Exclusive breastfeeding ☐ Exclusive breast milk substitute ☐ Mixed feeding ☐ Other (specify): _____

Maternal outcome: ☐ Alive ☐ Dead

Child status: ☐ Still birth ☐ Neonatal death ☐ Alive

H. CHILD FOLLOW-UP REGISTER

Was a Dried Blod Spot (DBS) sample collected? ☐ Yes ☐ No If Yes, date of collection: ☐☐ / ☐☐ / ☐☐☐☐

	RESULT	Date of Sample collection (dd/mm/yyyy)	Date Caregiver received results (dd/mm/yyyy)
1st PCR (EID) Done: ☐ Yes ☐ No	☐ Positive ☐ Negative	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐
2nd PCR (EID) Done: ☐ Yes ☐ No	☐ Positive ☐ Negative	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐
Rapid Test at <12 months) Done: ☐ Yes ☐ No	☐ Positive ☐ Negative	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐
Rapid Test at 18 months) Done: ☐ Yes ☐ No	☐ Positive ☐ Negative	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐

Referred to ARV clinic: ☐ Yes ☐ No

ARV prophylaxis given: ☐ Yes ☐ No

Did the infant receive NVP within 72 hours of delivery? ☐ Yes ☐ No

Did the infant receive any of the following:

☐ Daily NVP until 1 week after cessation of breastfeeding ☐ Daily NVP for 6 weeks ☐ sdNVP + daily ZDV for 6 weeks ☐ Other ☐ Not Recorded

Infant received CPT: ☐ Yes ☐ No If YES, age of cotrim initiation: ☐☐ ☐ days ☐ weeks ☐ months

I. MATERNAL FOLLOW-UP REGISTER

Mother accessed Family planning: ☐ Yes ☐ No

If yes, method used: ☐ Hormonal ☐ Condom ☐ IUD ☐ Abstinence ☐ Other (specify):_____

Infant feeding method used: ☐ Exclusive breastfeeding ☐ Exclusive breast milk substitute ☐ Mixed feeding ☐ Other (specify):_____

Mother received CPT: ☐ Yes ☐ No

Maternal referral: ☐ Family Planning ☐ Support group ☐ Pap smear ☐ Other

Infant referral: ☐ EID ☐ OVC ☐ ART ☐ TB Evaluation ☐ Other